Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Medical Institute of South Texas

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-14-2388-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
April 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The physician felt that this service was medically appropriate, medically reasonable and medically necessary to aid in the healing of the compensable injury at the time of the surgery. Therefore, a "refund" is not indicated."

Amount in Dispute: $708.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the dispute packet submitted by the Medical Institute of South Texas for date of service 8/19/2013and will maintain our rationale for requesting a refund for the aforementioned dates of service as the Office found that services was denied for not medically necessary through the preauthorization process. Preauthorization # 1179668000 specifically denied the PRP injections with no record of the requesting physician appealing the denial of PRP injections."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 2013	15150, 11900	$708.17	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 196 – Payment denied/reduce for exceeded precertification/authorization

Issues

1. Did the respondent support denial of disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 196 – "Payment denied/reduced for exceeded precertification/authorization." 28 Texas Labor Code §134.600(p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section; Review of the submitted documentation finds prior authorization was requested but denied August 1, 2013 by the Utilization Review company Forte. The carrier's denial is supported.
2. The provisions of Division Rule 134.600 not met. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.